HIPAA BACKGROUND

HISTORY: The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC 1320d, among other changes, added "Administrative Simplification" requirements to the Social Security Act.

PURPOSE: HIPAA requirements are intended to standardize public and private financial and administrative health transactions and set minimum regulations for the storage, use, and transfer of health information.

RELEASE: The federal regulations implementing Administrative Simplification have staggered release dates. Covered entities must comply with the rule within two years of the release date (small health plans have three years).

- Electronic Transactions (financial and administrative)
- Privacy (Individually Identifiable Health Information)
- Security
- National Identifiers for health plans, health providers, and employers, (individual ID on hold)
- Enforcement
- Digital Signatures

PENALTY: HIPAA penalties range as high as $250,000 and not more than ten years in prison for wrongful disclosure of identifiable health information and over $1,000,000 in annual penalties for multiple violations of the transaction standards. Business associates that conduct transactions or share information with or on behalf of covered entities will be required to comply with HIPAA.

IMPACT: HIPAA is the largest government action in healthcare since Medicare. Only a small portion of the changes will be federally funded (ie. Medicaid). Current estimations are that at least 70% of HIPAA compliance is about changing business processes, not information technology. HIPAA takes advantage of Electronic Data Interchange (EDI) which is used in private industry currently, but now will be standardized. Standardization will result in less cost and more efficiency per transaction. Privacy and security of health information will become standardized and mandatory.

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Other web sites: Federal HHS HIPAA site is located at http://aspe.hhs.gov/admnsimp/ To look at implementation guides, visit: http://www.wpc-edi.com

RULE ONE – GENERAL and TRANSACTIONS

The first rule included both the General Provisions and the Transaction Standards. It was issued in August 2000 and must be implemented by October 16, 2002, except for small health plans which have an additional year.

The Transaction Standards regulations at 45 CFR 162 require certain organizations called "Covered Entities" to use only the HIPAA Standard codes and formats to conduct Transactions related to health care administration and financing. Covered entities must use only the mandated data content, standard codes, and standard formats when transmitting these types of transactions.

Covered entities include:

health plan – any (public or private) individual or group plan that provides or pays the cost of medical care in addition to named plans like Medicaid and Medicare, employee welfare benefit plans, group health plans.
health care clearinghouse – any public or private entity that processes health information received from another into standards or receives standard information and processes into non-standard for another.
health care provider – a provider of medical or health services, or any organization who furnished, bills, or is paid for health care in the normal course of business, and such provider transmits health information in electronic form in connection with a covered transaction.
Others are not covered, but are impacted: Sponsors of health plans (generally employers or government, conduct transactions with plans such as enrollment and premium payments), and Business Associates who act on behalf of covered entities (must sign a contract to abide by HIPAA).

Transactions are defined as the transmission of information between parties to carry out financial or administrative activities related to health care.

Standard Transactions include:

Health Care claims or equivalent encounter information
Health care payment and remittance advise
Coordination of benefits
Health care claim status
Enrollment and disenrollment in a health plan
Eligibility for a health plan
Health plan premium payments
Referral certification and authorization

The following transactions are also identified, but no standard has yet been released:

First report of injury; Health claims attachments; Others

RULE TWO - PRIVACY

The second rule (Privacy) was issued December 28, 2000. This regulation must be implemented by April 2003, except for small health plan which have an additional year. This regulation, at 45 CFR 164 also changed some of the general provisions in 45 CFR 160.

The rule specifies when and how Covered Entities and organizations that receive health information may transfer, disclose, protect, and receive consent or authorization from patients regarding this information. There are specific provisions for content of "business associate contracts" for sharing health information. General Information on privacy rule concepts:

Protected Health Information is health related information which identifies or could be used to identify an individual transmitted or maintained in *any* medium.

Minimum Necessary Standard -Covered Entities are required to make reasonable efforts to limit the Protected Health Information that is disclosed to others or used within the organization to the minimum necessary to accomplish the intended purpose.

State law preemption- all "contrary" state law is pre-empted. Any state law that is more stringent (provides more protection) is still valid.

Individual Rights - Individuals have the right to request access and copies to their patient records**,** request that their records be amended, receive information on who accessed their records, appeal denials to requests, get information about the entities privacy practices, request restrictions be added to use or communication of their health information, file complaints with the entity or Secretary of HHS.

Privacy Practices Notice- must be given to individuals, posted, and copies made available. Gives detailed information about the Covered Entity's uses and disclosures of Protected Information and describes the processes in place to allow individuals to exercise control over them.

Consent Form- Health care providers must have a signed consent form before they use or disclose Protected Health Information for purposes of healthcare treatment, payment, or operations. Covered Entities can require individuals to sign as a condition to treatment or enrollment.

Authorization Form- must be signed by the individual before use or disclosure of Protected Health Information for any other purpose (with few exceptions). Covered Entity cannot condition treatment or enrollment on signing authorization.

Business associate contract- are required for situations where Protected Health Information is disclosed to, or is created or received by a business associate on behalf of a Covered Entity.

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